



Do not use for West Nile virus disease

LHJ Use ID _____
☐ Reported to DOH Date ____/____/____
LHJ Classification ☐ Confirmed
☐ Probable
By: ☐ Lab ☐ Clinical
☐ Epi Link: _____

☐ Outbreak-related

LHJ Cluster# _____

LHJ Cluster

Name: _____

DOH Outbreak # _____

Arboviral Disease

County _____

REPORT SOURCE

LHJ notification date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age ____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____

☐ Derived

Diagnosis date: ____/____/____

Illness duration: ____ days

Signs and Symptoms

Type of arboviral disease (Do not use this form for WNV)

☐ Western Equine Encephalitis ☐ Eastern Equine Encephalitis

☐ St. Louis Encephalitis ☐ Japanese Encephalitis

☐ Dengue Fever ☐ LaCrosse

☐ Other: _____

Y N DK NA

☐ ☐ ☐ ☐ Fever Highest measured temp: ____ °F

Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ Nausea

☐ ☐ ☐ ☐ Vomiting

☐ ☐ ☐ ☐ Headache

☐ ☐ ☐ ☐ Stiff neck

☐ ☐ ☐ ☐ Eyes sensitive to light (photophobia)

☐ ☐ ☐ ☐ Confusion

☐ ☐ ☐ ☐ Muscle aches or pain (myalgia)

☐ ☐ ☐ ☐ Joint pain

☐ ☐ ☐ ☐ Seizures new with disease

☐ ☐ ☐ ☐ Rash

Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Previous infection with a flavivirus (e.g., dengue, SLE)

Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ Abnormal neurologic findings

☐ ☐ ☐ ☐ Altered mental status

☐ ☐ ☐ ☐ Ataxia

☐ ☐ ☐ ☐ Paralysis or weakness

☐ ☐ ☐ ☐ Rash observed by health care provider

☐ ☐ ☐ ☐ Lymphadenopathy

☐ ☐ ☐ ☐ Arthritis or arthralgia

☐ ☐ ☐ ☐ Meningitis

☐ ☐ ☐ ☐ Encephalitis or encephalomyelitis

☐ ☐ ☐ ☐ Jaundice

☐ ☐ ☐ ☐ Liver abnormality or failure

☐ ☐ ☐ ☐ Kidney (renal) abnormality or failure

☐ ☐ ☐ ☐ Hemorrhagic signs

Clinical Findings (cont'd)

Y N DK NA

☐ ☐ ☐ ☐ Complications, specify: _____

☐ ☐ ☐ ☐ Admitted to intensive care unit

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy Place of death _____

Vaccinations

Y N DK NA

☐ ☐ ☐ ☐ Japanese encephalitis or yellow fever vaccine in past Type: _____ Date ____/____/____

Laboratory

P = Positive O = Other

N = Negative NT = Not Tested

I = Indeterminate

Specimen type _____ Specimen type _____

Collection date ____/____/____ Collection date ____/____/____

P N I O NT

☐ ☐ ☐ ☐ ☐ Abnormal CSF

Profile: wbc ____ (% lymph ____ % neutr ____)
rbc ____ prot ____ gluc ____

☐ ☐ ☐ ☐ ☐ Viral antibodies with single elevated titer or ≤ 2-fold increase or virus-specific IgM by EIA without IgG confirmation (serum) [Probable]

☐ ☐ ☐ ☐ ☐ Viral IgM by EIA (CSF)

☐ ☐ ☐ ☐ ☐ Viral antibodies with ≥ 4-fold rise (serum pair)

☐ ☐ ☐ ☐ ☐ Viral IgM by EIA and IgG by another assay (e.g., PRNT) (serum or CSF)

☐ ☐ ☐ ☐ ☐ Virus culture or PCR (clinical specimen)

INFECTION TIMELINE

Enter onset date (first sx)
in heavy box. Count
backward to determine
probable exposure period

Days from
onset:

Exposure period

-15 -2

o
n
s
e
t

Calendar dates:

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or
outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____

☐ ☐ ☐ ☐ Case knows anyone else with similar symptoms

☐ ☐ ☐ ☐ Insect or tick bite

☐ Mosquito ☐ Tick

☐ Other: _____

☐ Unknown insect or tick type

Location of insect or tick exposure: _____

Date of exposure: ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Outdoor or recreational activities (e.g. lawn
mowing, gardening, hunting, hiking, camping,
sports, yard work)

☐ ☐ ☐ ☐ Blood transfusion or blood products (e.g. IG,
factor concentrates)

Date of receipt: ____/____/____

☐ ☐ ☐ ☐ Organ or tissue transplant recipient

Date of receipt: ____/____/____

☐ ☐ ☐ ☐ If infant, birth mother had febrile illness

☐ ☐ ☐ ☐ If infant, infected in utero

☐ ☐ ☐ ☐ If infant, breast fed

☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee,
visitor) Specify country: _____

☐ ☐ ☐ ☐ Occupational exposure

Lab worker ☐ Y ☐ N ☐ DK ☐ NA

Other: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Exposure details: _____

☐ No risk factors or exposures could be identified

☐ Patient could not be interviewed

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Neonatal
Delivery location: _____

☐ ☐ ☐ ☐ Pregnant
Estimated delivery date ____/____/____
OB name, address, phone: _____

☐ ☐ ☐ ☐ Did case donate blood products in the 30 days
before symptom onset Date: ____/____/____
Agency and location: _____
Specify type of donation: _____

☐ ☐ ☐ ☐ Did case donate organs or tissue (including ova or
semen) in the 30 days before symptom onset
Date: ____/____/____
Agency and location: _____
Specify type of donation: _____

PUBLIC HEALTH ACTIONS

☐ Breastfeeding education provided

☐ Notify blood or tissue bank

☐ Other, specify: _____

NOTES

Investigator _____ Phone/email _____

Investigation complete date ____/____/____

Local health jurisdiction _____